PEACHTREE SPINE
PHYSICIANS

5555 Peachtree Dunwoody Rd NE, Suite G65
Atlanta, GA 30342
Fax: (678) 539-6570

Request for Access To and Authorization for Use and Disclosure of Protected Health Information

Name: _____
(First) (Middle) (Last) (Maiden/Other Name)

Date of Birth: _____ Phone #: _____ Medical Record #: _____

Address: _____ City: _____ St: _____ Zip: _____

I hereby authorize Peachtree Spine Physicians to Disclose my Protected Health Information to:

Name: _____ Attn: _____

Address: _____ City: _____ St: _____ Zip: _____

Relationship: _____ Phone: _____ Fax: _____

RECORD DELIVERY METHOD (select one):
- ☐ Secure Electronic Access
- ☐ Mail (via US Postal Service)
- ☐ Pick up at Peachtree Spine Physicians

Email: _____

INFORMATION TO BE RELEASED
- ☐ Medical Records
- ☐ Billing Records
- ☐ Diagnostic Films
- ☐ Other: _____

DATES OF INFORMATION:
From:_____ To:_____
From:_____ To:_____
From:_____ To:_____
From:_____ To:_____

I SPECIFICALLY AUTHORIZE RELEASE OF INFORMATION RELATING TO:
- ☐ Substance abuse (including alcohol / drug abuse)
- ☐ Mental health or behavioral health
- ☐ HIV related information (AIDS related testing)
- ☐ Genetic testing

PURPOSE OF DISCLOSURE:
- ☐ Personal ☐ School ☐ Research
- ☐ Changing physicians ☐ Consultation
- ☐ Insurance / Worker's Compensation
- ☐ Legal (specify): _____
- ☐ Other (specify): _____

_____ _____
Signature of patient or personal representative Date

ACKNOWLEDGEMENT OF UNDERSTANDING:
I understand that the expiration date of this authorization is _____, or if no date is specified it will expire 90 days after the date of signature. I have the right to revoke this authorization in writing, except (i) to the extent that the Practice has acted in reliance upon this Authorization; or (ii) to the extent that the Authorization was obtained as a condition of obtaining insurance coverage; or (iii) there is other law that grants the insurer the right to contest a claim under the policy. Written notification must be provided to the Practice's Privacy Official / Committee at the address provided on this document. I understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State privacy regulations. By authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care. I understand that if I am being requested to authorize a use or disclosure that, upon request, I will get a copy of this form after I sign it. I understand my request will be acted upon within 30 days. If I am not provided access or information cannot be supplied, I understand I will be notified, and have the right to request review of any denial of access other than those made in accordance with applicable law. I understand that I may be required to pay the cost of creating paper copies or electronic media, mailing copies, supervising my inspection, or preparing a summary except for uses and disclosure for the purpose of treatment, payment and operations.

The cost of medical records for personal use will be at no cost, with additional requests at the cost of **$6.50** + delivery charges *per request* and payment due in advance. Requests for xray/MRI images (on a disc) will be at **$10** + delivery charges *per disc* with payment due in advance. All requests for records provided directly to a healthcare provider for continuing care will be processed at no cost, and all other requests will be billed at applicable regulated and other rates, with payment due in advance. For questions, please contact **ResolveROI at 844-887-8109**.

I acknowledge and understand terms of this **Request for Access to / Authorization for Use and Disclosure of Protected Health Information**.

Patient / Legal Representative signature: _____ Date: _____

Relationship to Patient: _____

INVOICE METHOD: MAIL: _____ FAX TO:_____ EMAIL TO:_____ OTHER:_____